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## Case Report: Abortus Spontan Incomplete

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### CASE REPORT

A woman patient on behalf of NWM aged 28 years came with her husband to Community and Primary Health Care Center complaint of rupture of membranes and fetus with placenta going out at home, 3.5 hours before go to Community and Primary Health Care Centre (Puskesmas). When the incident occurred, the patient was at home, and the patient pulled the placenta by herself. The patient was not in strenuous activity, and there was no prior history of vaginal bleeding before. The patient has no fever and does not suffer any pain. The calculation of the first day of last menstruation on April 30, 2017, shows that her second pregnancy is 22 weeks old. First pregnancy miscarriage at 17 weeks' gestation. The patient suffered severe nausea and vomiting during the first semester of pregnancy and was admitted to the Puskesmas Nusa Penida I for four days with a diagnosis of hyperemic gravidarum. Patients did not immediately go to the Puskesmas because they had to bury their babies first in Setra. After knowing the occurrence of blood seep and arising pain in the lower abdomen, the patient asked her husband immediately took her to the Puskesmas.

Patients only perform ANC (Antenatal care) once on 6 July 2017 at 8 to 9 weeks' gestation. On lab examination when ANC: HGB 9.8 g/dl, blood sugar 125 mg/dl, ultrasound GS (+), and BJJ/Fetal Heart Beat (+). During pregnancy the patient's appetite is not good, the patient only eats rice without side dishes. Patients can not eat vegetables and fruit because they feel nauseated. The patient has had a miscarriage during the first pregnancy. At that time the pregnancy was 17 weeks old. Miscarriage occurred at the family home in Denpasar and immediately taken to Puri Raharja Hospital. There is done curettage and hospitalized. The patient had no history of diabetes mellitus disease, hypertension, UTI, and hormonal disorders. In her family there was no one experiences the same illness. The

patient's knowledge of health and hygiene was good. The patient had no family history of diabetes mellitus disease, hypertension, and other degenerative diseases.

The patient worked at the Community and Primary Health Care Center as a contract midwife. She and her husband opened a photocopy business, which according to the patient using a large enough capital, thus making the patient worried. The patient lives with her parents-in-law, where everyday the both of them were in the fields and returns home at night. Patients have difficulty communicating with both her parents-in-law, so if there is a problem the patient prefers to call her parents. The patient's last education was D3 (Associate's degree) Midwifery, and her husband was a high school graduate. The patient thinks that pain is a medical illness. Other than that, the patient also thinks that she has a sin that causing the second miscarriage. Patients are worried that a routine examination of a midwifery specialist will cost a lot and interfere with her activities as a midwife and photocopier because she has to cross the island. Although the pain does not interfere with the patient's activity as a midwife or as a photocopier business entrepreneur, the patient feels worried and hopes that the same thing will not happen in the next pregnancy.

On physical examination, the vital signs for blood pressure 120/80 mmHg, pulse 84x/min, respiratory 18x/min, body temperature 36.7°C, body mass index 22.7, and good nutritional status. The general physical examination is good and no abnormalities found in the lungs or heart. Investigations performed a complete blood examination and ultrasound. In the complete hematological blood examination found abnormalities, increased leukocyte  $11,71.10^3/uL$ , and low HB 10.8 g/dl, the other all within normal limits. On ultrasound examination saw the remaining tissue results intrauterine conception.

According to the diagnosis of incomplete spontaneous

abortion, the patient underwent medical curettage to clean up the remaining conception in the uterine cavity, because when there was any remaining conception, uterine muscle contraction would be disrupted and bleeding will continue. Before the patient's medical action, there were several things to do beforehand. The first was to explain to the patient and her family what action would be done, the purpose, and what the risks were. Then we asked the patient to fill out the informed consent form. The patient got RL infusion fluid with 20 drops per minute. Prophylactic antibiotics were administered, in the form of 2-gram intravenous bolus ceftriaxone injection. After the patient's action, the patient was given intramuscular 10 IU oxytocin injection and oral drug administration: 500 mg ciprofloxacin antibiotic three times a day, ibuprofen anti-inflammatory-analgesic 400 mg 3 times a day, and one tablet of ferrous sulfate twice a day. The patient was admitted to the Community and Primary Health Care Center under the supervision of the midwife. Given education to patients to rest, take regular medication and eat food with good nutritious. To the family in education about the recurrent diagnosis of recurrent spontaneous abortion, what are the factors causing it and the danger of complications, why it can occur repeatedly, and asked the family to take care and monitor the patient.

### **Biological Diagnosis and Psychosocial Diagnosis**

The biological diagnosis of this case is recurrent incomplete spontaneous abortion. Spontaneous abortion is an abortion that occurs naturally without outside intervention (artificial) to end the pregnancy<sup>1</sup>. Incomplete abortion is diagnosed when a part of the conception has been born or palpated in the vagina, but some are still left behind<sup>1</sup>. In this patient, the abortus had occurred for the second time, so it was a recurrent abortion, but not a habitual abortion. Habitual abortion is a spontaneous abortion that occurs three times in a row<sup>1</sup>. Several risk factors in this patient were such as physiological stress, previous abortion experience, anemia, poor nutrition due to patient hyperemesis, and possibly weak uterine conditions that need to be studied further by referring to a gynecologist. The source of water from the patient's home can also be a source of infection that can cause abortion. The diagnosis of abortion can be expected when a woman in reproductive age complains of vaginal bleeding after a late and mule some period which is reinforced by the determination of early pregnancy on bimanual examination and biological and immunologic pregnancy tests. We should notice the kind and amount of bleeding, the cervical opening, and the presence of tissue in the uterine or vaginal cavity. In the incomplete abortion, the presence of vaginal bleeding is either slight or significant depending on the remaining tissue. The cervix is open because there is still tissue left in the uterine cavity that is considered a foreign object. Therefore the uterus will try to remove it by contraction so that the mother felt the pain. The size of the uterus is smaller than the gestational age and gestational sac that are already difficult to recognize. We need to think of a pelvic infection, ovarian tumor/cyst, and appendicitis as the differential diagnosis. Symptoms accompanying pelvic infection usually occur during menstruation and are rare

after amenorrhea. The symptoms are lower abdominal pain and palpable resistance on vaginal examination which is generally bilateral. In pelvic infection, the difference in rectal and armpit temperatures exceeds 0.50 ° C, in addition to leukocytosis higher than ectopic pregnancy and pregnancy test shows a negative result. Symptoms and signs of early pregnancy, amenorrhea, and vaginal bleeding are usually absent in pelvic infection. Ovarian cysts are larger and more rounded than ectopic pregnancies. In appendicitis, we will not find any tumor and pain in uterine cervical movements such as those found in ectopic pregnancy. Lower abdominal pain in appendicitis lies at the point of McBurney.

As is known above, the patient has several risk factors and because of limited resources in the community and primary health care center cannot be known the exact causative diagnosis. There are several factors causing abortion. Fetal factors, namely genetic disorders, zygote growth disorders, embryo, fetus, and placenta. Maternal factors, namely endocrine factor (hormonal), immune factor (immunity), infection, cervical muscle weakness, and deformity of the womb. The increased leukocyte  $11,71.10^3/uL$  showed the presence of infection. Father's factors are chromosomal abnormalities, sperm infection, and old age. Genetic factors which the most frequent causes are fetal chromosomal abnormalities, genetic abnormalities, and most commonly are aneuploidy (abnormalities of chromosomal composition). The psychological factor which is an immature emotion of the women. In this case, the abortion occurred for the second time in a row, so it causes psychological trauma and endangers the next pregnancy. Economic and occupational factors are very influential on the psychological of this patient. Psychological factors are also exacerbated by the lack of communication resulting in less harmonious family relationships, where family support is critical to maintaining emotional stability from patients in order not to affect subsequent pregnancies. Nutritional factors, particularly severe malnutrition, are most likely to predispose to abortion. In this case, the patient's hyperemesis and poor dietary patterns lead to malnutrition during pregnancy, wherein a low Hb level of 10.8 g/dl was found. Thus further examination is required by referring the patient to the gynecologist in the referral hospital, as a preventive of recurrent abortion occurrence in subsequent pregnancies<sup>2,3,4</sup>.

The diagnosis of social psychology was a feeling of disappointment, sadness, and guilt that arose after the abortion raised the patient's concern the same thing will happen in the next pregnancy. The patient thinks that she had sinned, causing the second miscarriage. Patients are worried that a routine examination of a midwifery specialist will cost a lot and interfere with her activities. The patient hopes the same thing does not happen in the next pregnancy. Both parents-in-law are less concerned with the patient's condition, so patients prefer to consult their parents over the phone if there is a problem that needs to be discussed. This psychological impact can be a risk factor for subsequent recurrent abortion events if not treated. The way to overcome it is with the full support of

husbands, parents, family, colleagues, and friends<sup>5</sup>.

### PROBLEM FORMULATION

The problem, in this case, is not about management for recurrent incontinence spontaneous abortion. The exciting and challenging aspects of this case are: 1) How to keep the psychologically traumatized patients due to a second abortion; 2) The poor patient's diet for the pregnant mother's nutrition resulting in anemia; 3) Socio-economic stress that adds to psychological disorders during pregnancy; and 4) Seeks the primary cause that causes recurrent miscarriage in these patients.

### DISCUSSION

Abortion case is a public health problem because it gives an impact on pain and the death of the mother. Abortion can cause complications that lead to the death of the mother<sup>2,6</sup>. By definition, abort is the end of a pregnancy (by certain consequences) at or before the age of 20 weeks of pregnancy or pregnancy has not been able to live outside the womb<sup>7</sup>. According to the chronology of the process can be divided into abort spontaneously (occurring without intervention from the outside and without an apparent cause) and artificial abort (abort action that was deliberately done to eliminate pregnancy before age 28 weeks of pregnancy or fetal weight is equal to or less than 500 g). Based on the condition of the conception results in the womb is elaborated on several types of imperial abortion, abortus insipient, incomplete abortion, complete abortion, missed abortion, and abortion habitually<sup>8</sup>. Complications of abortion that could culminate in maternal death are several, mainly due to bleeding and infection. Massive bleeding can lead to severe anemia resulted in the death of the mother because it leads to kidney failure and shock, and infection can result in sepsis<sup>6,9</sup>. This condition happened due to remaining conception results in the placental site, that is called by abort incomplete. The rest of the results of this conception must be released in order to stop the bleeding soon<sup>9</sup>.

Abortion also has an impact on the psychological conditions and conditions of socio-economy of the victims. Due to the incidence of this abortion can cause trauma and depression for the sufferer causing suicidal tendencies. Moreover, the impact of the crisis of confidence for the sufferer<sup>5</sup>. The medical procedure for an abortion is not cheap and has an impact on the aspect of the socio-economics of patients in the long-term. The impact of psychological aspects and the socio-economy aspects of abortion cause the sufferer becomes less productive than before<sup>10</sup>.

The emotional impact obtained in post-abortion patients is grief, numbness and shock, and disbelief. The role of midwives in restoring emotional post-abortion patients through the provision of counseling after curettage is critical. The role of midwives care for post-abortion patients often does not occur due to fear of being involved more deeply with heartache and stress so that patients need to keep their distance. The most important of the psychological recovery of the patient is the role of the husband and family that provide support and motivation

with the husband and family working together to maintain the feelings of the patient and support the spirit and give more attention to the health of the patient. In this case, the husband's support was very high, even though from the parents and in-laws the patient lacked good communication. Patient's community environment is essential to keep guarding the patient's feelings by not discussing the patient's abortion history and always giving motivation, as well as giving the same treatment as other people. The psychological recovery of the patient after this abortion is related to the activation of the role of the standby husband, standby midwife, and alert village.

Prevention of abortion can be done by identifying the causes. Causes include ovum factor, maternal factor (genetic tract disorder, placental circulatory disorder, maternal disease, rhesus antagonist, maternal age, parity), paternal factor (advanced age, chronic disease), growth factor of conception, chromosomal factors, endometrial environmental factors, anemia, and external influences (drugs, economic status, education and occupation of mother). In maternal factors, in the early three semesters of pregnancy is very susceptible to abortion caused by fetal growth disorders and malformations, the age factor of pregnant women who are less than 20 years are very susceptible to abortion due to immature female reproductive organs, while pregnant women aged above 35 years susceptible to abortion due to reduced reproductive function, chromosomal abnormalities and the presence of chronic disease, and the increasing number of deliveries will be more at risk of abortion<sup>1,8,9</sup>. The socioeconomic and educational conditions of pregnant women have a significant impact on the risk of abortion, the risk of abortion is higher if the level of education is low and the social position is low<sup>11</sup>.

The handling of abortion cases both in clinical and prevention efforts is not only the responsibility of doctors alone but the responsibility of various professions, both health professions and other professions across sectors. They must work together in an interprofessional collaboration to create safe and quality health services.

The problem faced by this family is the lack of cohesiveness in dealing with the patient's illness from the onset of hyperemesis gravidarum in the first three semesters of pregnancy, then the patient feels less attention by both in-laws to deal with the problem makes the patient more stressed. Psychological stress is also due to the patient's economy that is pioneering the photocopying business which is considered to be very costly and takes a long time to restore that is business capital. In order for the patient to be calmer in facing the problem, briefing the patient is needed on her illness and the risk factors caused by psychological disorders. Collaborating with nutritionists in providing nutritional information is very important to explain adequate and appropriate nutrition for pregnant women. Providing education to the family about the importance of psychological support to pregnant patients and post abort patients in order to avoid excessive trauma and adverse consequences in subsequent pregnancies, as we know patients with abortion experience will lead to the



potential for further abortion events, especially those that occur in succession more than once.

The healthcare for this case, it is vital to do cooperation and collaboration from the medical personnel, paramedics (midwives), pharmacy personnel, Mother and Child Health program holders as well as across sectors such as government apparatus, non-governmental organizations and others. Handling for the above cases requires interprofessional collaboration (IPC) starting from receiving patients by registering staff, midwifery assessment by midwives, medical review by doctors based on data collected through the midwifery management process and reported by midwives, establishing the diagnosis, establishing the plan for patient management and providing therapy. Laboratory analysts conduct laboratory tests requested by the doctor. Nutrition officers conduct an assessment of nutritional problems in patients.

IPC in the case of abortion begins with the role of midwives who take steps in the midwifery management process that starts from basic data collection to evaluation. These steps form a complete framework that can be applied to each situation, consisting of:

#### 1. Data collection / assessment

Gather accurate, complete information from all sources related to the patient's condition. Data acquisition is obtained through history.

#### 2. Data interpretation: Identification of problems or diagnoses

Physical examination, including the general condition of the patient, vital signs, and physical examination of the patient which includes inspection, palpation and if necessary carry out investigations.

#### 3. Identification of potential diagnoses / problems

Identify the problem/diagnosis that has been identified.

#### 4. Identify immediate / collaborative actions

Immediate action on the patient's condition which is considered harmful to the patient. This action is carried out in collaboration and referrals based on the patient's condition. The factor that plays a role in post curettage abortion is the process of providing postabortion care services, in which patients require counseling, attention, understanding, and empathy during the provision of care. In giving care for the first abortion, the first thing that has been done is to overcome the immediate situation, namely bleeding and shock. After the mother is stable, the important care given is pain relief, psychological support, post-abortion counseling, and further examination as needed.

#### 5. Comprehensive care plan

Problem-solving planning is divided into goals, implementation plans, and evaluations.

#### 6. Implementation of care

Activities carried out by midwives in the community are those that cover implementation plans that are in line with the objectives to be achieved.

#### 7. Evaluate the results of care

This evaluation was conducted to evaluate the effectiveness of the midwifery care measures provided. Evaluation results can be basic data for establishing

diagnoses and subsequent plans. What is evaluated is whether the diagnosis is appropriate, the care plan is effective, the problem is resolved, the problem has been reduced, new problems arise, and the needs have been met. Midwifery evaluation in the case of post curettage incomplete abortion includes good conditions, and normal vital signs, no signs of shock, and bleeding in the birth canal.

The midwife affirms that the family plays a role in patient care to report patient complaints and problems care, as supervisors and motivators for patients taking medication as well as following care instructions. Maternal and Child Health Officers conducted an epidemiological investigation of the patient's family and found the risk factors of abortion. Maternal and Child Health Officers provide education on the prevention of abortion.

Collaboration from various professions is essential for good service quality. Good cooperation and understanding the role of each profession is certainly necessary for providing services to the community. The patient and family-centered approach require a better inter collaborative approach. When misunderstandings exist between these professions, especially in communication, patient safety can be threatened.

Constraints in the implementation of interprofessional collaboration for patients is the activity of other officers, as well as the lack of ideas and ideas from other interprofessional collaboration teams. Implementation of interprofessional collaboration is still a doctor centrist where the assumption that the hierarchy of the position of the doctor profession is the highest in the management of patients in the field.

Precautions of abortion cases with a family-centered approach and community-centered by performing a standby system (standby husband's, standby midwife's and the standby of village). Standby husbands consist of:

#### 1. Ready

Preparing for the money saved for the wife who will give birth and for the emergency:

##### a. Maternal Maternity Savings.

In this case, the husband did not make an effort to set aside money for Maternal Maternity Savings and only relied on financing from the government health insurance, even though the patient as a midwife was aware of this program. In this case where the location is on the islands, sometimes funds outside of health insurance are needed such as sea transportation if it has to be referred. So it is important to give further counseling to the husband and his family regarding the importance of Maternal Maternity Savings.

##### b. Social Fund Maternity

In the community of patients, there is no effort to collect Social Fund Maternity funds. Important Social Fund Maternity is to be a discussion in cross-sectoral meetings. The Maternal Maternity Savings and Social Fund Maternity program is important for the

prevention and treatment of patients' socioeconomic stress that can worsen the patient's condition and become a factor in the occurrence of recurrent abortion.

c. Prepare Prospective Blood Donor.

These efforts form a group of blood donor providers for PMI to have the availability of blood at any time needed. At our puskesmas, there is no blood supply and blood donor service, and if you need a blood transfusion, the patient is referred to the district hospital in the city center.

## 2. Deliver

- a. Preparing transportation to the delivery and handling of the emergency.
- b. The husband is expected to have a commitment to escort and accompany his wife to check her pregnancy to the village midwife to know the development and condition of pregnancy of his wife, support the wife to give birth to the village midwife, and help prepare with maternal maternity savings, and do not forget to remind the wife to check her pregnancy at least 4 times (once the first quarter, once the second quarter, and two thirds of the quarter). In this case, the husband was very committed in escorting and accompanying patients in the process of antenatal examination, only patients who were midwives were less disciplined in examining their pregnancies.

## 3. Keep

- a. Accompany the wife at the time of maternity.
- b. Recommend immediate breastfeeding after birth, do not give another food, only give breast milk.
- c. Escort and accompanying his wife and baby to check up a week after giving birth to<sup>12, 13, 14, 15</sup>.

The standby village is a village whose inhabitants have the readiness of resources and the ability and willingness to prevent and solve health problems, disasters, and emergency health emergencies independently. The standby village consists of a standby midwife and citizens, in realizing the blood bank of the village or blood donor groups, maternity transport (ambulances village), Tabulin (maternal maternity savings) and Dasolin (Social Fund maternity). The involvement of all components of society like religious figures, community leaders, health workers, legislative leadership, and the private sector is very dominant in realizing the village standby. But since May 2006, it has been established that the term of standby village is replaced with the term P4K (Program Planning Maternity and Prevention of Complications). This change was made to prevent confusion in society and irregular term of standby village. Enacted in the Decree of the Minister of Health of the Republic of Indonesia with the number: 564/Minister of Health/SK/VIII/2006 on 2 August 2006 in Guidelines for Implementation of the Standby Village Development describing the overall activities of various aspects related to public health up to disaster preparedness and emergency might happen in the village<sup>16</sup>.

The standby village is a community empowerment program in the field of health that aims to lower maternal and infant mortality in long-term, where its success was influenced

by the performance of the village midwife, commitment and participation the community.

The village midwives assigned to serve one or two villages as the region of workplace, responsible to the head of the clinics in the region, and cooperate with the villager, which aims to lower infant mortality, number of maternal mortalities, and promoting healthy lifestyles to society, by do the educate and service of posyandu, Dasa Wisma, and aid for childbirth<sup>17</sup>. So, it could be said that the success of the standby village program depends on the active role of the village midwife.

It is concluded that the role of the family, especially the husband and the community is very important in preventing the occurrence of abortion. In this case, the patient's living conditions are quite distant from the other residence where the husband and parent-in-law who only return home late at night is very dangerous if there was an emergency event such as a spontaneous abortion, we advise the patient to seek a neighborhood that is more crowded or near the photocopy business. Currently, the patient and her husband are already living in the Mess of community and primary health care center of Nusa Penida 1, so it is expected to be safer for this family. However, we also advise patients and their husbands to be more open and communicate with local people, so it can be reduced psychological pressure and if there is an emergency event can get help immediately.

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